TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
KTS Partners Inc

Respondent Name
Farmington Casualty Co

MFDR Tracking Number
M4-21-0093-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
September 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The maximum allowable reimbursement amount for home health services provided through a licensed home health agency shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies."

Amount in Dispute: $135.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement has been issued in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation and no additional reimbursement is due."

Response submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2020 April 2, 2020	Home Health Services	$135.99	$16.84

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.215 sets out the fee guidelines for home health services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4141 – The payment is based on the Texas Medicaid Home Health Agency fee schedule
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

What rule is applicable to reimbursement?

Findings

The requestor is seeking additional reimbursement for home health services rendered in March and April of 2020. The insurance carrier reduced the payment based on the workers' compensation fee guidelines.

28 Texas Administrative Code §134.215 states in pertinent part, the maximum allowable reimbursement (MAR) amount for home health services provided through a licensed home health agency shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

Review of the Texas Medicaid fee schedule for the dates of service and code submitted found the allowable to be $27.00. The total number of units billed was four. The MAR is calculated ad $27.00 x 4 x 125% = $135.00. The insurance carrier paid $118.16. An additional payment in the amount of $16.84 is due to the requestor.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $16.84.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $16.84, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 15, 2020 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.